altus dental™

**Altus Dental Insurance Company, Inc.**
PO Box 1557
Providence, RI 02901-1557
877-223-0588

# ENROLLMENT FORM

## I. SUBSCRIBER INFORMATION

| Subscriber Name (First, Last) | | Date of Birth (MM/DD/YYYY) | Social Security / I.D. # | |
|---|---|---|---|---|
| Street Address / P.O. Box No. | Apt. No. | City | State | Zip |
| Email Address | | | | |

## II. GROUP INFORMATION

| Employer / Group Name | Group No. | Division No. | Date of Hire | Location No. (if applicable) |
|---|---|---|---|---|
| Ipswich Public Schools | | | | |

## III. ENROLLMENT INFORMATION

**EFFECTIVE DATE OF ACTION (MM/DD/YYYY)**

**QUALIFYING EVENT**

- ☐ Open Enrollment
- ☐ New Hire/Re-hire
- ☐ Marriage
- ☐ Divorce
- ☐ Birth or Adoption
- ☐ Workers' Compensation
- ☐ Return from Leave of Absence
- ☐ Loss of Coverage
- ☐ Full-Time/Part-Time Status
- ☐ Death of a Member

**ACTION CODE**

*Check one.*
*Changes typically made on the first of the month.*

ADDITIONS
- ☐ New Subscriber
- ☐ Add Dependent to Family
- ☐ Reinstatement

TERMINATION
- ☐ Remove Subscriber
- ☐ Remove Dependent
- ☐ List name in Section IV

STATUS CHANGE
- ☐ Name / Address Change
- ☐ Transfer from Sublocation # _____ to # _____
- ☐ Change Type of Coverage (Please indicate change, e.g. Individual to Family, in "Type of Coverage" section below.)

COBRA
- ☐ Reinstatement of Subscriber
- ☐ Addition of Dependent Prior ID # _____

**TYPE OF COVERAGE**

*Check one.*

- ☐ Individual
- ☐ Family

**HIGH / LOW**

*Check one.*

- ☐ High
- ☐ Low

## IV. DEPENDENT INFORMATION

***Group must have student rider.**

| First Name | Last Name (if different) | Date of Birth (MM/DD/YYYY) | Relationship | Check if student over 19* |
|---|---|---|---|---|
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |
| | | | | ☐ |

## V. DENTIST INFORMATION

*List the dentist(s) you or your covered family members use.*

| Dentist(s) Last Name, First Name | City / Town | Patient(s) Last Name, First Name |
|---|---|---|
| | | |
| | | |

## VI. COORDINATION OF BENEFITS

**Are you or any of your dependents covered by another DENTAL plan?** ☐ **No** ☐ **Yes** *If Yes, please complete the section below.*

| Policyholder Name (First, Last) | Policyholder I.D. No. | Group I.D. No. |
|---|---|---|
| Dental Insurance Company | Dental Insurance Address (Street, City, State, Zip) | |
| Employer Name (through which you/your dependents have coverage) | | |

I certify that all information is correct to the best of my knowledge. I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with underwriting guidelines. If my employer requires employee contributions for this coverage, I authorize the deductions of these amounts from my wages periodically.

Employee Signature _____ Date _____

Benefits Administrator Authorization _____ Date _____

**NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY**

Altus Dental does not discriminate on the basis of race, color, national origin, age, disability, or sex.

**Español (Spanish):** ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-223-0588.

**Português (Portuguese):** ATENÇÃO: Se fala português, encontramse disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.